# EMERGENCY MEDICAL TECHNICIAN
## *ENHANCED SKILL*
## PHYSICIAN PRECEPTOR SIGNATURE FORM

***Medical Director to initial each skill authorized (*required)**

**O Multi-Lumen Airway _____**
**O Nebulized Medications _____**
**O IV Maintenance _____**
**O Epinepherine (First Responders Only) _____**
**O Manual Defibrillation_____**
**O Dextrose 50% (I-85 only) _____**

***Please complete and return to:*** **North Dakota Department of Health**
**Division of Emergency Medical Services**
**600 E Boulevard Ave – Dept 301**
**Bismarck ND 58505-0200**

In addition to their EMT skills, the following persons possess Advanced Life Support skills association with above named enhancement course. As required in Chapter 50-03-03 of the North Dakota Administrative Code, these persons have met the training requirements of the North Dakota State Department of Health for these skills, and I have assumed responsibility for the services of such persons as set forth below.

| | 6 Digit State License Number | Name |
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| 15. | | |

The above named are affiliated with _____ (ambulance service, rescue squad, etc.) within the geographic area of my practice. These persons are allowed to provide the ALS skill designated by me as part of my practice and only as a result of my delegation of the authority to do so. The above name person(s) must also have current certification to perform named skill. I may revoke this authority at any time. If I do so, I will provide the Division of Emergency Medical Services with written notification of the revocation. This document expires March 31, 20_____.

| | | |
|---|---|---|
| Physician Name – Print | Medical License Number | Business Telephone |
| | | |
| Physician Signature | Address | Date |